California Tobacco Control

UPDATE 2006

The Social Norm Change Approach

California Department of Health Services
Tobacco Control Section

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California Department of Health Services, Tobacco Control Section

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The first California Tobacco Control Update (August 2000) established statewide measures and described trends in tobacco-related attitudes, behaviors, policies and activities. The second (2002) and third (2004) Updates reported on trends, data and policies from which progress in tobacco control could be assessed. This fourth update (2006) highlights progress in tobacco control using the framework of logic models developed by the Centers for Disease Control and Prevention (CDC) for evaluating comprehensive tobacco control programs. This report provides background information on California's tobacco control environment, describes the social norm change strategies with the support of updated evidence, and presents the trend for long-term outcomes as a reflection of current California tobacco control efforts.

The Program: Moving toward a Tobacco Free California

Since its inception 17 years ago, the goal of the California Tobacco Control Program (CTCP) has been to decrease tobacco-related diseases and deaths in California by reducing tobacco use across the state. The landmark 1988 California Tobacco Tax and Health Promotion Act (Proposition 99) enabled California to become the first state to implement a comprehensive tobacco control program and begin working toward this goal.

The CTCP's comprehensive nature, as well as its strength, results from the combined efforts of its constituent parts: the California Department of Health Services Tobacco Control Section (CDHS/TCS), the University of California's Tobacco Related Disease Research Program, and the California Department of Education's Safe and Healthy Kids Program Office, Tobacco Use Prevention Education program. CDHS/TCS administers and coordinates the tobacco control efforts of 61 local health departments, hundreds of trained and experienced public health workers, thousands of adult and youth volunteers, approximately 100 community-based organizations, including seven priority population partnerships, a statewide media campaign, a tobacco cessation helpline, and statewide technical support services.

The Challenge: California Remains a Tobacco Control Battleground

As it has for 17 years, the CTCP's work to reduce and eliminate tobacco use and second-hand smoke exposure occurs in the context of the well-funded and ever-shifting market tactics of the tobacco industry.

Undaunted by the Master Settlement Agreement (MSA) in 1998, which resolved claims by 46 states against six major U.S. cigarette manufacturers accused of marketing to minors and misleading the public about the safety of their products, the tobacco industry continues to increase the marketing and promotion of tobacco products in California and across the nation. Tobacco industry marketing strategies have evolved over time; most recently, cigarette companies have spent more of their marketing dollars in retail outlets than in any other venue. On average, California retailers have 24.9 cigarette marketing materials per store; more than two-thirds of stores have at least one piece of marketing material located at a height less than three feet, and therefore easily seen by young children; and the amount of cigarette advertising per store is higher in stores with lower prices.[1] The tobacco industry is also carrying out aggressive marketing campaigns in adult-only venues such as bars. In 2005 alone, there were thousands of adult-only

tobacco-related bar events advertised or announced in California. Tobacco companies also target other venues, such as community events, fraternity events on college campuses, and sports events. In the first half of 2006, tobacco companies sponsored 40 sports events in California.[2]

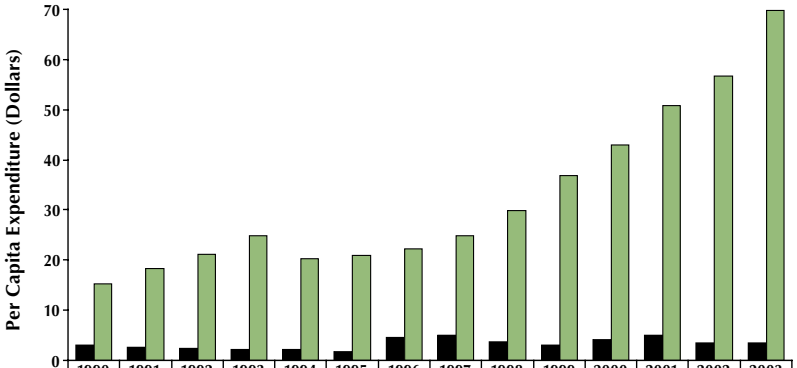
In 2003, the tobacco industry spent 20 times more money on tobacco advertising in California than the CTCP spent on its entire program.

The tobacco industry's strategies and techniques targeting certain segments of the population are continually changing in order to increase tobacco consumption and to avert cessation efforts. The 2004 Kool DJ Mixx campaign exemplified the multi-channel methods used by the tobacco industry. This campaign included a series of tobacco-sponsored bar nights where samples of newly designed Kool Fusion specialty-flavored menthol cigarettes were distributed; advertisements in magazines such as Rolling Stone and Vibe in which a Kool Mixx CD was attached to the advertisement; direct mail promotions; and a DJ Web site, all designed to reach young urban African Americans.[3]

Indirect marketing of tobacco products and depictions of smoking are ubiquitous in movies. From May 2004 to April 2005, more than half of the movies reviewed contained pro-tobacco messages and 56 percent of the movies showed tobacco use, whereas only approximately a quarter of the movies reviewed contained anti-tobacco messages.[4] Movie stars and other featured actors lit up in 50 percent of all movies, thereby sending a powerful message to young people that tobacco use is an acceptable, even desirable, activity.[5]

The tobacco industry's advertising and promotional spending has always dwarfed CTCP funding, and the disparity continues to grow. In the early years of the CTCP, the tobacco industry's expenditures for advertising were five times the CTCP's budget; and in 2003, the industry outspent the CTCP by a ratio of 20 to 1 (Figure 1).[6,7] Fifteen years after the inception of the CTCP, the per capita budget for tobacco control in California ($3.44) was well below the $5.12 - $13.71 per capita range recommended by the CDC for funding an effective statewide tobacco control program in this state.

Figure 1: Per Capita Tobacco Industry and Tobacco Control Expenditures in California, 1990-2003

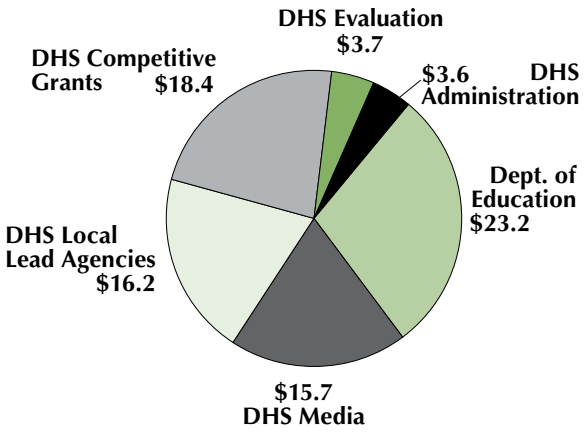


	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
CTCP	$3.11	$2.52	$2.46	$2.12	$2.08	$1.78	$4.68	$5.01	$3.67	$3.10	$4.11	$4.91	$3.47	$3.44
Tobacco Industry	$15.30	$18.43	$21.13	$24.88	$20.24	$20.90	$22.21	$24.94	$29.78	$36.88	$42.95	$50.82	$56.70	$69.75

Source: Federal Trade Commission Cigarette Report for 2003,
California Department of Health Services, Tobacco Control Section
Prepared by: California Department of Health Services, Tobacco Control Section, 2006.

Limited resources for tobacco control efforts in a state as large as California make it imperative to focus on population-level interventions. As a result, the CTCP budget, excluding that spent by the Department of Education, is primarily dedicated to funding mass media campaigns, tobacco control initiatives by local health departments, and competitive grants for community based organizations (Figure 2). Grass roots efforts have proven to be the impetus for statewide policies, such as the elimination of self-service tobacco sales and the groundbreaking ban on smoking in bars and restaurants.

Figure 2: California Tobacco Control Program Budget, 2005-2006 (in millions)



The Paradigm: Social Norm Change Drives California's Tobacco Control Program

The CTCP's aim is to change the broad social norms around the use of tobacco by "indirectly influencing current and potential future tobacco users by creating a social milieu and legal climate in which tobacco becomes less desirable, less acceptable, and less accessible."[8] The social norm change model is based on the concepts that "the thoughts, values, morals and actions of individuals are tempered by their community" and "durable social norm change occurs through shifts in the social environment of local communities, at the grass roots level" (See Figure 3).[8]

Under this social norm change paradigm, the CTCP focuses its tobacco control activities on these priority areas:

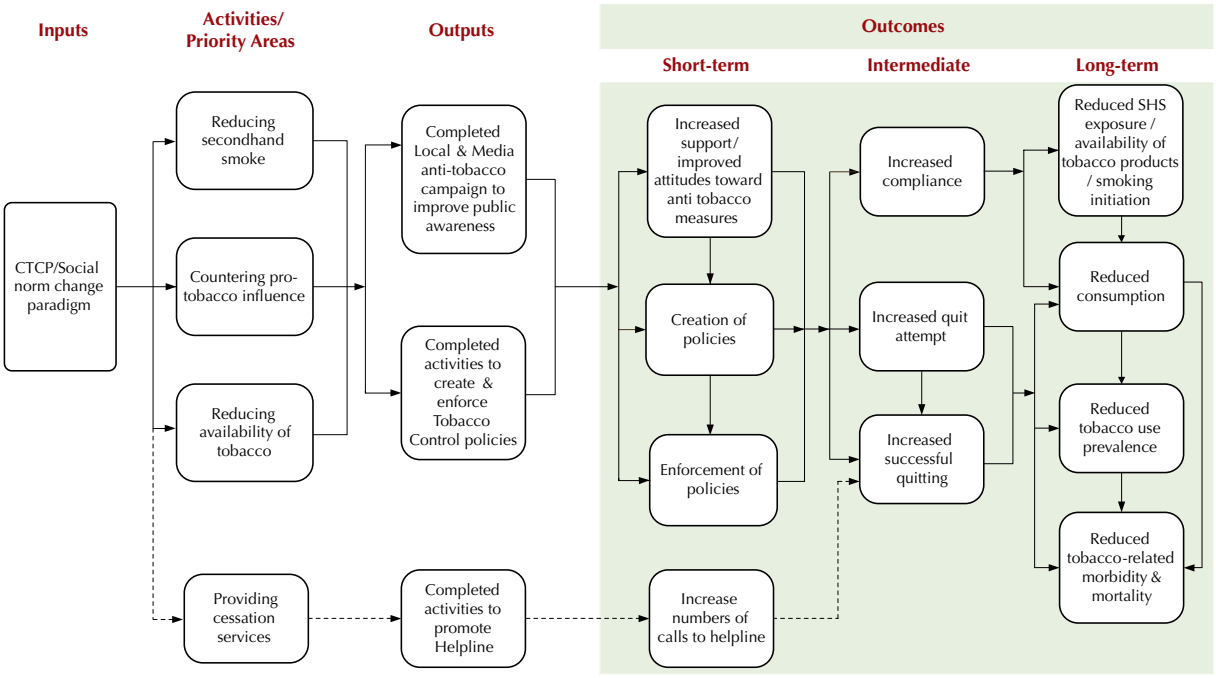
(1) Countering pro-tobacco influences in the community: working to curb tobacco product retail advertisements and marketing practices, tobacco industry sponsorship, and the depiction of tobacco products in the entertainment industry.

(2) Reducing the exposure to secondhand smoke: initiatives that employ a policy and advocacy approach to restricting smoking in public and private places (emerging areas include policies associated with Indian casinos, multi-unit housing, and outdoor venues).

(3) Reducing tobacco availability: supporting enforcement of the existing law that prohibits selling tobacco to minors, elimination of free tobacco product sampling, licensing of tobacco retailers, and establishment of tobacco-free pharmacies.

The CTCP's projects aim to change the broad social norms around the use of tobacco by "indirectly influencing current and potential future tobacco users by creating a social milieu and legal climate in which tobacco becomes less desirable, less acceptable, and less accessible."[8]

Figure 3: California Tobacco Control Program/Social Norm Change Paradigm As a Logic Model



Adapted from *Key Outcome Indicators for Evaluating Comprehensive Tobacco Control Programs.* Centers for Disease Control and Prevention, 2005

As a complement to the social norm change paradigm, the CTCP supports operation of the California Smokers' Helpline, as well as provides support for community-based cessation programs.

Countering Pro-tobacco Influences

The CTCP reveals and counters tobacco industry influences through the STORE Campaign, Project SMART Money, and the Tobacco Education Media Campaign.

The CTCP reveals and counters tobacco industry influences through the STORE Campaign, Project SMART (Sponsorship Mission: Avoid Reliance on Tobacco) Money, and the Tobacco Education Media Campaign. The STORE Campaign aims to mobilize communities throughout California to initiate local policy action to restrict and enforce tobacco sales and marketing practices; facilitate better enforcement of local and state laws that focus on retail advertising and tobacco sales; and advocate that the federal government grant authority to state and local governments to regulate cigarette advertising and marketing practices.

The Project SMART Money Workgroup acts as an advisory body to support the CTCP-funded projects that address the area of tobacco sponsorship, to support efforts of the California Attorney General in monitoring and enforcing the Master Settlement Agreement with regard to sponsorship, and to identify emerging sponsorship issues. In May 2006, the efforts of Project SMART Money and the Attorney General's office resulted in a $5 million settlement with R. J. Reynolds to resolve a lawsuit over the firm's distribution of free cigarettes on public grounds.[9]

The Tobacco Education Media Campaign was designed to offset the tobacco industry's heavy marketing as well as its deceptive public relations campaigns in California.[10] The main outcome of the Tobacco Education Media Campaign has been to affect attitudes and beliefs. This strategy is based on the idea that a change in attitudes often precedes a behavior change, such as an individual's smoking behavior. For example, anti-industry ads serve to expose the marketing and product manipulation tactics of the tobacco industry. CDHS/TCS data show that these types of ads are memorable and exposure to them is associated with anti-industry attitudes and beliefs. Furthermore, these anti-tobacco attitudes and beliefs are associated with more quit attempts, higher intentions to quit, and lower smoking prevalence.[11]

Secondhand Smoke

Since its inception, the CTCP has focused on building awareness of the health consequences of secondhand smoke exposure, and has both benefited from and given support to grass roots movements across the state working to establish protective no-smoking policies to decrease people's exposure to secondhand smoke. California emerged as a national and world leader on this issue, setting the precedent for many other states and nations.[12,13]

"The science is clear: secondhand smoke is not a mere annoyance but a serious health hazard that causes premature death and disease in children and nonsmoking adults." Richard Carmona, U.S. Surgeon General [14]

Californians have passed hundreds of local ordinances requiring smoke-free restaurants, workplaces, and common areas since the early 1990s.[13] California became the first state to implement smoke-free indoor workplace laws in 1995 and a smoke-free bar law in 1998.[12] California also started the trend of passing local secondhand smoke ordinances in "new frontiers" such as beaches, multi-unit housing, entryways, playgrounds, and college campuses. For example, there are currently 14 local ordinances for smoke-free private entries and doorways and 17 local smoke-free outdoor dining policies. Reflecting one of the most recent trends, as of June 2006, there were 25 California beaches prohibiting smoking. These ordinances demonstrate the strength of local tobacco control movements, which have been fueled by the social norm in California against tobacco use and secondhand smoke.

Secondhand smoke policy efforts have also made significant progress at the state level. In 2004, Assembly Bill 846 was implemented; this law prohibits smoking within 20 feet of main entrances, exits, and operable windows of all public buildings.[15] In 2005, Assembly Bill 384 was enacted, which prohibits the use of tobacco products by inmates, staff, and visitors in California correctional facilities.[16]

Public opinion overwhelmingly supports secondhand smoke policies in California:

- In 2005, 93.5 percent of California diners preferred eating in smoke-free restaurants, with nearly 80 percent of smokers preferring smoke-free dining (78.8 percent), up from 43.4 percent in 1994.[11]

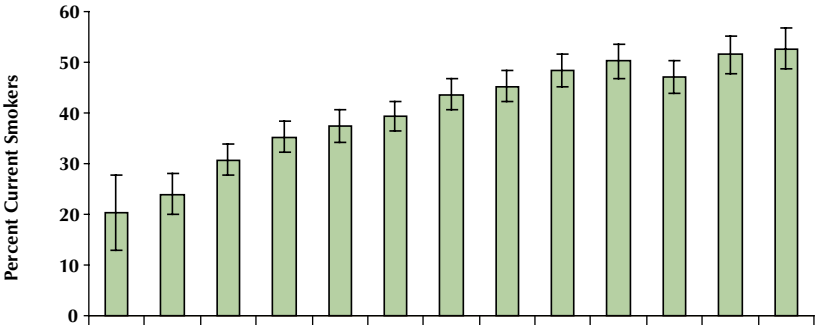
From its inception in 1992 through June 2006, the Helpline has provided assistance to almost 400,000 people.

- In 2006, the majority of Californians agreed on a variety of secondhand smoke-related issues.[11]
  - 72.2 percent of Californians agreed that smoking should be prohibited in outdoor dining areas at restaurants.
  - 58.6 percent of Californians preferred public beaches to be smoke-free.
  - 71.7 percent of Californians agreed that smoking should not be allowed in Indian casinos.

As secondhand smoke ordinances and policies increase in number and strength, secondhand smoke exposure has become less socially accepted. An increasing number of Californians are protecting themselves and the people in their households:

- In 2005, 76 percent of California households did not allow any smoking in the home, up from 51.3 percent in 1993, a nearly 50 percent increase.[17]
- In 2005, over 50 percent of California smokers reported living in a smoke-free home, a dramatic increase compared to 23.9 percent in 1994 (Figure 4).[17]

Figure 4: Percent of California Smokers Who Prohibit Smoking in their Household, 1994-2005



	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
California	20.3	23.9	30.8	35.3	37.4	39.4	43.6	45.3	48.3	50.3	47.1	51.5	52.7

Source: Behavioral Risk Factor Surveillance System and California Adult Tobacco Survey data, 1993-2005. The data is weighted to 2000 California population.
Prepared by: California Department of Health Services, Tobacco Control Section, 2006.

Smoking restrictions in the workplace and the home have been associated with higher rates of cessation attempts and lower rates of relapse in smokers who attempt to quit.[18] In 2002, 76.8 percent of smokers who live and work in smoke-free environments are light smokers (meaning they smoke less than 15 cigarettes per day), and 70.3 percent of smokers who live and work in smoke-free environments tried quitting within the last year.[19]

Secondhand smoke ordinances help smokers quit. In 2004, more than half (51.7 percent) of former smokers who quit after the state smoke-free workplace law went into effect agreed that the law made it easier for them to quit. In addition, 69 percent of current smokers reported that the smoke-free law made it easier for them to reduce their cigarette consumption.[20]

Availability of Tobacco

Raising the price consumers pay for tobacco products can contribute to reducing the availability of tobacco through decreased affordability.[21-25] Since 1988,

Californians have voted twice and the legislature has moved once to increase the tobacco tax in order to promote public health:

- In 1988, Proposition 99 increased the tax on a pack of cigarettes by 25 cents, and created an equivalent tax on other tobacco products.
- In 1993, the legislature increased cigarette taxes by 2 cents per pack to fund breast cancer research and early detection services.
- In 1998, Proposition 10 increased the tax an additional 50 cents.

After Proposition 10 passed, the state's tax per pack became the current 87 cents. Despite these multiple tax increases, California ranks 23rd among states by cigarette tax rate.[26] Furthermore, Californians still support a higher tobacco tax. In 2005, 56.4 percent of California adults supported a cigarette tax increase of at least 1 dollar per pack, and 79.1 percent supported a tax increase of 25 cents or more per pack.[11]

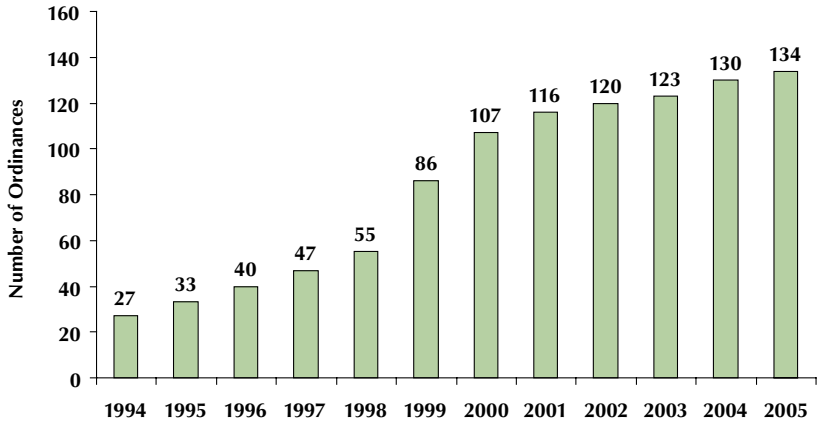
California's statewide tobacco control laws help reduce the availability of tobacco products and paraphernalia to adults and youth. Penal Code Section 308 and the Stop Tobacco Access to Kids Enforcement (STAKE) Act of 1995 make it illegal to sell tobacco to anyone under the age of 18.[27,28] The STAKE Act requires every business that sells tobacco to post a STAKE Act age-of-sale warning sign where tobacco sales take place, such as near a cash register.

Many statewide anti-tobacco laws can trace their origins to activism at the local level. Californians' concerns about the tobacco industry's marketing practices prompted the passage of local ordinances to ban self-service tobacco sales. The number of such ordinances increased almost five-fold from 1994 to 2005 (Figure 5).[29] This policy proliferation at the local level led to the enactment and expansion of a state law that bans self-service display of tobacco products and tobacco paraphernalia, including cigarettes, chewing tobacco, dipping tobacco, snuff, cigars, bidis, pipe tobacco, roll your own tobacco, and any other product containing tobacco.[30,31]

Local jurisdictions have also focused on access to tobacco products and have increased the number of retail licensing

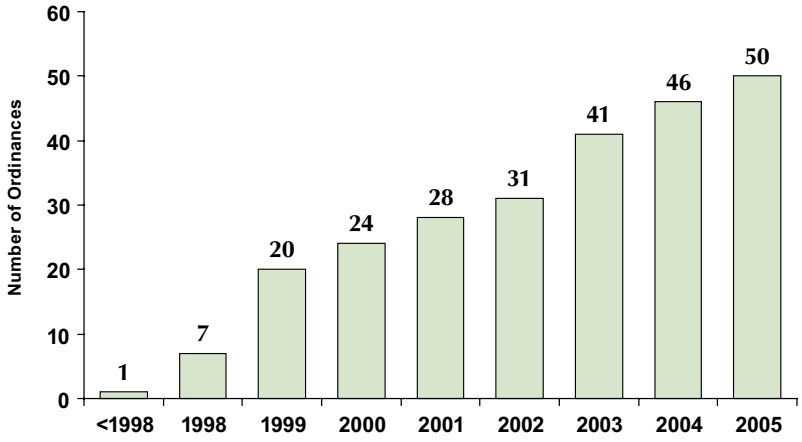
"The single most direct and reliable method for reducing consumption is to increase the price of tobacco products, thus encouraging the cessation and reducing the level of initiation of tobacco use." (Taking Action to Reduce Tobacco Use, National Academy of Sciences, Institute of Medicine)[25]

Figure 5: Cumulative Number of Local Ordinances Passed on Banning Self-service Tobacco Sales, 1994-2005



Note that these are the years in which the ordinance was last amended.
Source: Local Tobacco Control Ordinance Database-California updated June 2006, maintained by American Nonsmokers' Rights Foundation.
Prepared by California Department of Health Services, Tobacco Control Section, 2006.

Figure 6: Cumulative Number of Local Tobacco Retailer Licensing Ordinances, 1998-2005



Note that these are the years in which the ordinance was last amended.
Source: Local Tobacco Control Ordinance Database-California updated June 2006, maintained by American Nonsmokers' Rights Foundation.
Prepared by California Department of Health Services, Tobacco Control Section, 2006.

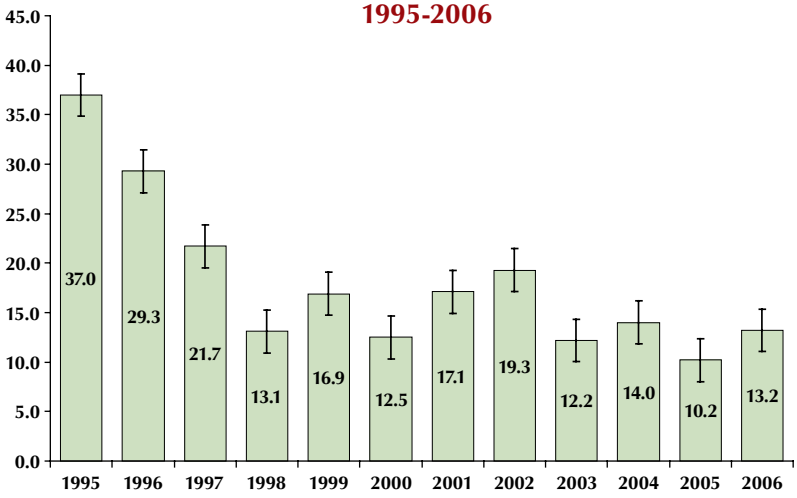
ordinances by 100 percent from only 5 years ago; such ordinances now number a total of 50 (Figure 6).[29] This push for retail licensing at the local level culminated in a state law that requires businesses selling cigarettes and other tobacco products to the public to have a California Cigarette and Tobacco Products License.[32]

Legislation aimed at reducing the availability of tobacco is backed by strong public support. Recent data show that over 80 percent of Californians agree that store owners should have a license to sell cigarettes and that cigarette vending machines should be totally prohibited.[11] In addition, strengthened enforcement efforts as well as a growing number of state and local ordinances have resulted in tremendous declines in the rate of illegal tobacco sales to minors. Between 1995 and 2006, the illegal sales rate decreased from 37 percent to 13.2 percent (Figure 7).[33]

Cessation

For smokers who want help quitting, the CTCP funds local program cessation services, as well as the California Smokers' Helpline, a toll free telephone counseling service. The California Smoker's Helpline is the principle program at the state level specifically addressing smoking cessation using an individual behavior change approach. From its inception in 1992 through June 2006, the Helpline has provided assistance to almost 400,000 individuals.[34]

Figure 7: Percent of Retailers Selling Tobacco to Youth, 1995-2006

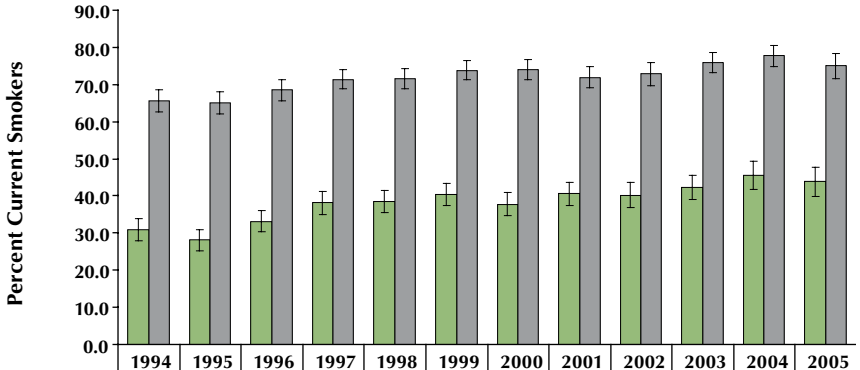


Attempted buy protocol 1995-1996; Actual buy protocol 1997-2006.
Source: Youth Tobacco Purchase Survey, 1995-2006.
Prepared by: California Department of Health Services, Tobacco Control Section, 2006.

As Californians have become increasingly anti-tobacco in their views and assertive in protecting the rights of nonsmokers, many smokers have been motivated to move toward cessation. The percentage of current smokers

who reported that they were thinking about quitting either in the next 30 days or the next 6 months increased between 1994 and 2005 (Figure 8).[17] In 2005, 44 percent of California smokers thought of quitting within the next 30 days and 75 percent thought of quitting within the next 6 months.[17]

Figure 8: Proportion of California Smokers Thinking About Quitting, 1994-2005



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Next 30 Days	30.9	28.1	33.2	38.1	38.5	40.5	37.8	40.6	40.2	42.3	45.6	43.9
Next 6 Months	65.6	65.1	68.5	71.4	71.6	73.8	74.0	71.9	72.8	75.8	77.7	75.0

Sources: Behavioral Risk Factor Surveillance System and California Adult Tobacco Survey data, 1994-2005.
The data is weighted to 2000 California population.
Prepared by: California Department of Health Services, Tobacco Control Section, 2006.

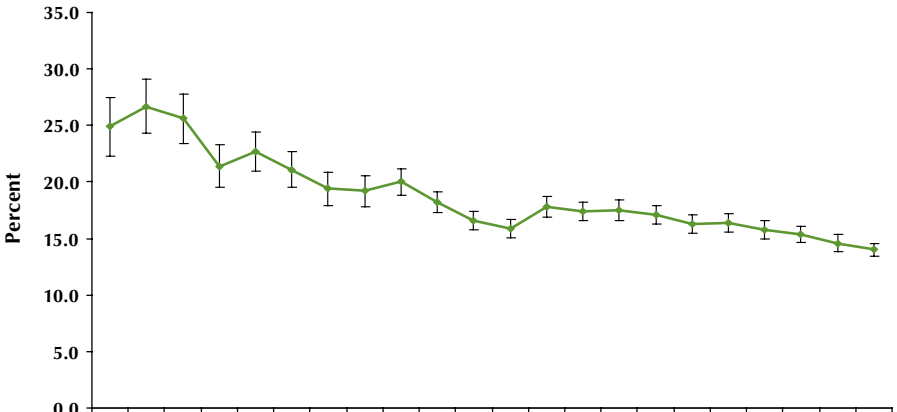
Experience shows that tobacco control efforts focusing on individual behavior change are costly, difficult to implement in a state as large and diverse as California, and may not bring about lasting societal change. In contrast, the social norm change paradigm has led to significant reductions in smoking prevalence and exposure to second hand smoke. In fact, the CDC has identified the CTCP as a model of "best practices" for a comprehensive tobacco control and prevention program.[35] A recent California study showed that the progress California has seen in the priority areas under the social norm change paradigm is strongly related to a decrease in smoking prevalence, cigarette consumption, and secondhand smoke exposure.[11]

The Results: Prevalence and Disease Rates Decline

An effective tobacco control program should be able to reduce tobacco use and, ultimately, lead to a decline in tobacco-related disease. California's experience using the social norm change approach shows that the reduction of tobacco use can be achieved. Despite the CTCP's funding challenges, smoking prevalence has declined over time for both California adults and youth, and cigarette consumption has declined overall and among current smokers.[17,19,36] Independent research has also linked the increasing social unacceptability of smoking, which is the immediate purpose of the CTCP's social norm change paradigm, to the reduction of cigarette consumption in California.[37] Alongside the declines in smoking prevalence, there is strong evidence that efforts by the CTCP have also resulted in declines among tobacco-related diseases.[38-40]

Alongside the declines in smoking prevalence, there is strong evidence that efforts by the CTCP have also resulted in declines among tobacco-related diseases.

Figure 9: Smoking Prevalence Among California Adults, 1984-2005*



	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
CA	24.9	26.7	25.6	21.4	22.7	21.1	19.4	19.2	20.0	18.2	16.6	15.9	17.8	17.4	17.5	17.1	16.3	16.4	15.8	15.4	14.6	14.0

*Definition change in 1996 resulted in an increase in the number of "occasional smokers" being counted.
Sources: Behavioral Risk Factor Surveillance System (BRFS), 1984-1992; BRFS and California Adult Tobacco Survey data, 1993-2005.
The data is weighted to 2000 California population.
Prepared by: California Department of Health Services, Tobacco Control Section, 2006.

California Adult Smoking Trends

Overall, smoking prevalence has steadily declined since the CTCP started its comprehensive tobacco control efforts. Smoking prevalence has declined by 33.6 percent from 21.1 percent in 1989 to 14.0 percent in 2005 (Figure 9).[17, 41] The decline was most dramatic in the early years of the program (1989 to 1994); the rebound in smoking prevalence in 1996 is an artifact of the change adopted in the definition of "current smoker."

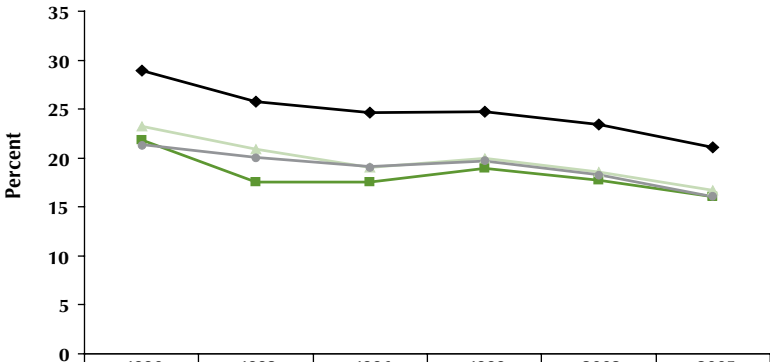
Smoking prevalence has significantly declined from 21.1 percent in 1989 to 14.0 percent in 2005.

Currently, smoking prevalence in California is among the lowest in the nation. In 2004, cigarette smoking prevalence in California was the lowest among all the states for adults older than 25, according to the National Survey on Drug Use and Health sponsored by the Substance Abuse and Mental Health Services Administration.[42]

Gender/Age

In 2005, smoking prevalence for both males and females was at historical lows. California men have had consistently higher smoking prevalence rates than women.[17]

Figure 10: California Male Smoking Prevalence by Race/Ethnicity, 1990-2005



	1990	1993	1996	1999	2002	2005
African-American	28.9	25.8	24.6	24.8	23.5	21.0
Asian/PI	21.8	17.6	17.6	18.9	17.7	16.1
Hispanic	23.3	20.9	19.0	20.0	18.5	16.7
Non-hispanic White	21.4	20.1	19.2	19.7	18.3	16.0

Source: California Tobacco Survey, 1990-2005, weighted to 1990 California population.
Adapted from Al-Delaimy, et al. *The California Tobacco Control Program: Can We Maintain the Progress?*[43]
Prepared by: California Department of Health Services, Tobacco Control Section, 2006.

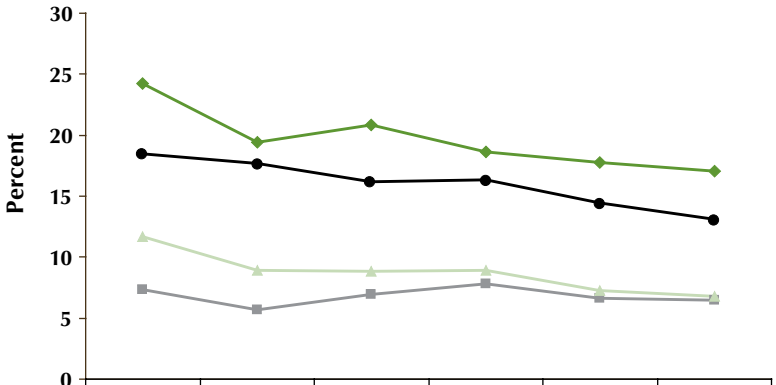
Smoking prevalence in all age groups has enjoyed a steady decline since 1996.[17] Young adults 18-24 years old remain the group with the highest smoking prevalence. Even so, prevalence among the 18-24 age group has dropped considerably (almost 20 percent) from its peak in the early 2000s. As a result, the gap between

the four age groups has narrowed.[17]

Priority Populations

California is arguably the most diverse state in the country. Although smoking prevalence among all major racial/ethnic groups has declined since the beginning of the CTCP, there are significant differences in smoking prevalence between these groups in California (Figure 10, 11). In 2005, African American males had higher smoking prevalence than their counterparts in the rest of the major race/ethnic groups. African American and non-Hispanic white females had significantly higher smoking prevalence than that of Hispanic and Asian/Pacific Islander females.[43]

Figure 11: California Female Smoking Prevalence by Race/Ethnicity, 1990-2005



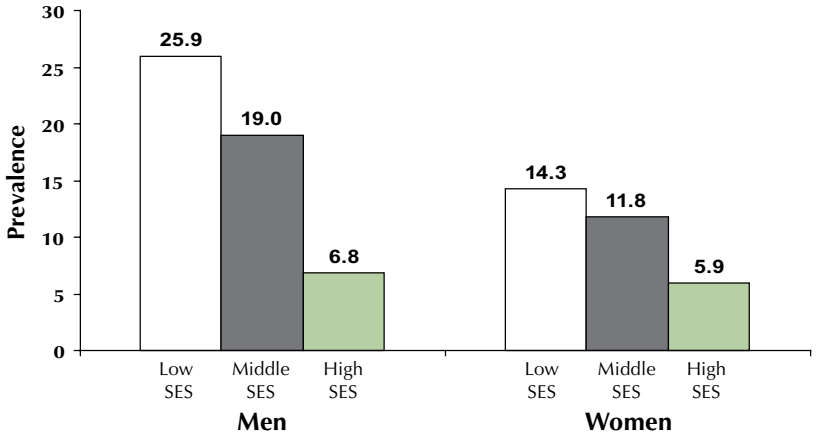
	1990	1993	1996	1999	2002	2005
African-American	24.2	19.4	20.9	18.6	17.8	17.1
Asian/PI	7.3	5.7	6.9	7.8	6.6	6.5
Hispanic	11.7	8.9	8.9	8.9	7.2	6.8
Non-hispanic White	18.5	17.7	16.2	16.4	14.5	13.1

Source: California Tobacco Survey, 1990-2005, weighted to 1990 California population.
Adapted from Al-Delaimy, et al. *The California Tobacco Control Program: Can We Maintain the Progress?*[43]
Prepared by: California Department of Health Services, Tobacco Control Section, 2006.

During 2002-2004, the CTCP funded five studies to collect statewide tobacco use information among active duty military personnel, Asian Indian, Chinese, Korean, and lesbian, gay, bisexual, and transgender (LGBT) populations in California. The studies showed that smoking prevalence in the LGBT community was 30.4 percent—double the state average.[44] Among active military stationed in California, Marines reported the highest smoking rate at 26.9 percent, about 50 percent higher than California men overall.[45] Similarly, Korean men had a smoking prevalence rate of 27.9 percent.[46] In contrast, the Chinese and Asian Indian smoking prevalence was much lower than the state average.[47-48]

Certain populations in California, specifically the low SES group, present unique challenges for the CTCP. Smoking is much more prevalent in this group than in the middle and high SES groups (See figure

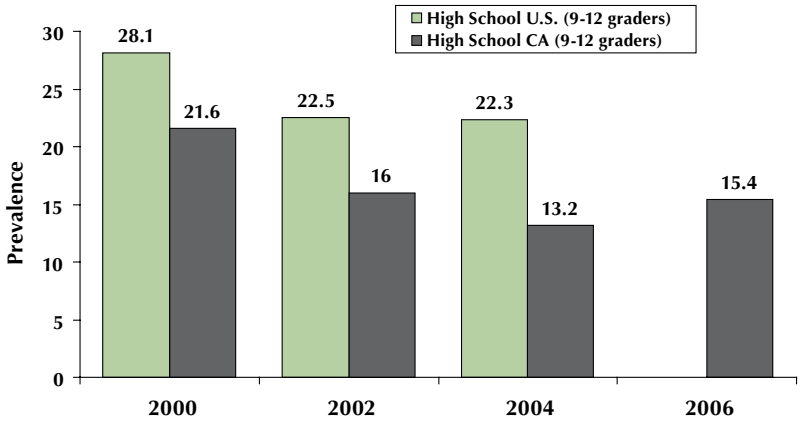
Figure 12: Adult Smoking Prevalence in California by Socioeconomic Status (SES) and Gender, 2005



Source: Behavioral Risk Factor Surveillance System and California Adult Tobacco Survey data, 2005. The data is weighted to the 2000 California population.
Note Low SES is defined as household income less than $25,000 and highest educational status is high school graduate. High SES is defined as household income of more than $50,000 and educational status is college undergraduate degree or more.
Prepared by: California Department of Health Services, Tobacco Control Section, 2006.

12).[17] Furthermore, implementing effective tobacco control programming for the low SES population can be difficult because it encompasses individuals across multiple ethnicities and both genders. In addition, the social and health issues faced by the low SES population are many and varied, and the tobacco industry markets aggressively to this segment of California's population. The male, non-Hispanic white, low-SES group have a smoking prevalence stands at 25.0 percent—consistently higher than smoking prevalence among the middle and high SES groups.[17]

Figure 13: 30-day Smoking Prevalence for California and U.S. High School Students (9th-12th Grade), 2000-2004



Source: The 2000 data is from the National Youth Tobacco Survey collected by the American Legacy Foundation, which used passive parental consent. The 2002, 2004, & 2006 data is from the California Student Tobacco Survey, which used active parental consent.
Prepared by: California Department of Health Services, Tobacco Control Section, 2006.

California Youth Smoking Trend

Youth smoking prevalence has declined dramatically in California, although in the most recent year smoking prevalence has started to rise (Figure 13).[36] This rise has been seen nationally as well.[49] It is not clear if this increase is due to an underlying cohort effect, a decrease in the real price of cigarettes in California and the U.S., which can have a large impact on youth smoking, or a decrease in national tobacco control mass media.

California smokers consume fewer cigarettes than smokers in the rest of the U.S. on a daily basis.

Nevertheless, California youth have a significantly lower smoking prevalence compared to the rest of the U.S.; California had the second lowest youth smoking prevalence in the nation in 2004.[36,42,50]

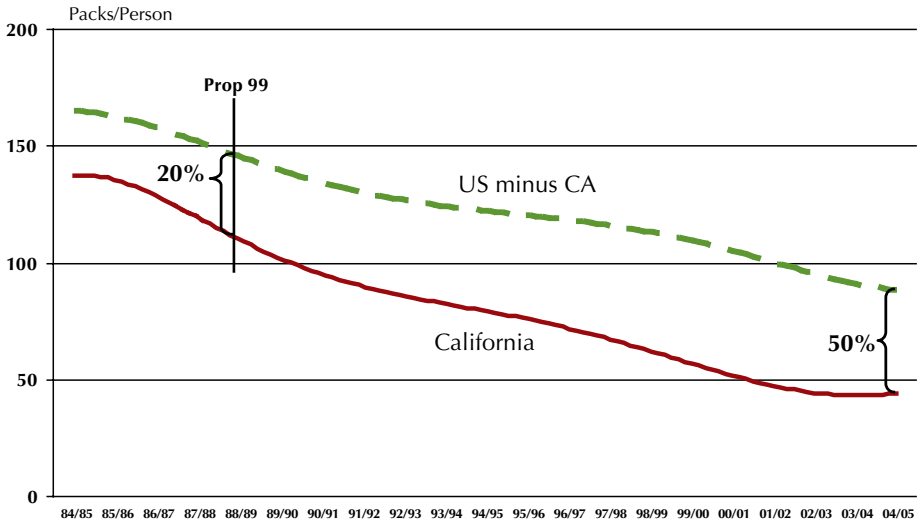
California Smokers Smoking Less

California smokers consume fewer cigarettes than smokers in the rest of the U.S. on a daily basis. Reducing the number of cigarettes smoked to fewer than 15 cigarettes per day and/or making significant quit attempts have been shown to be important factors in advancing toward successful quitting.[51]

The decline in the number of smokers and average number of cigarettes smoked per day, as well as the increase in the proportion of California smokers who are occasional smokers, are reflected in the downward trend in per capita cigarette consumption. From fiscal year 1989-1990 to fiscal year 2004-2005, per capita consumption declined by nearly 60 percent (56.9 percent) in California while per capita consumption for the entire U.S. declined by 36.7 percent during this

same time period (Figure 14).[26] In fact, per capita cigarette consumption in California was the lowest of any state in the nation during the 2004-2005 fiscal year.[26]

Figure 14: California And U.S. Minus California Adult Per Capita Cigarette Pack Consumption, 1984-2005



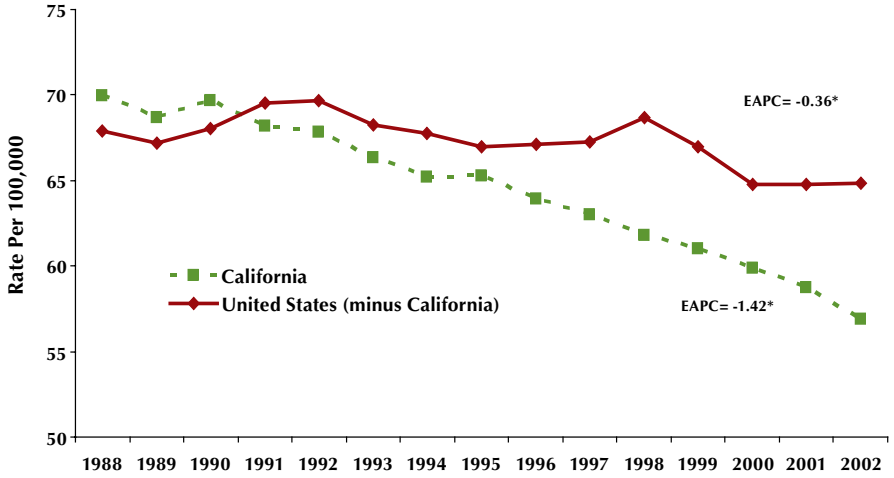
Source: California State Board of Equalization (packs sold) and California Department of Finance (population). U.S Census, Tax Burden on Tobacco, and USDA.. Note that data is by fiscal year (July 1-June 30).
Prepared by: California Department of Health Services, Tobacco Control Section, 2006.

Tobacco-related Diseases Declining Faster in California

The ultimate goal of any tobacco control program is to reduce tobacco-related diseases. Research has found the benefits of smoking cessation to be "substantial and begin to accrue almost immediately after quitting."[52] Long-term abstinence has even greater health benefits.

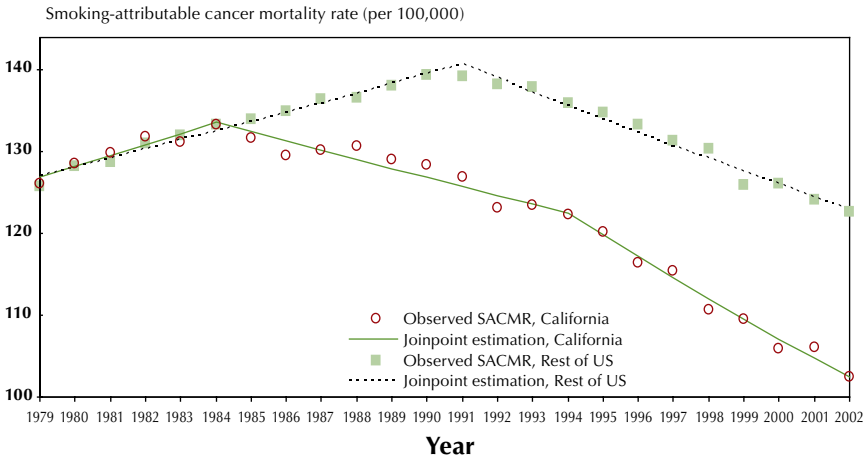
Accelerated reductions have been documented in California for both heart disease deaths and lung cancer incidence rates.[38,39] From 1988-2002, lung and bronchus cancer rates in California declined at 4 times the rate of decline in the rest of the U.S. (Figure 15).[40] Researchers have associated these declines with the efforts of the CTCP.[38,39] Greater declines in smoking-related morbidity and mortality are likely to be seen in the future as tobacco control efforts strengthen and increase.

Figure 15: Lung and Bronchus Age-adjusted Cancer Incidence Rates[1], 1988-2002



[1] Rates are per 100,000 and age-adjusted to the 2000 U.S. standard (19 age groups); Percent changes were calculated using 2 years for each end point; EAPCs were calculated using weighted least squares method.
* The EAPC is significantly different from zero ($p<0.05$).
Source: Cancer Surveillance Section. Prepared by: California Department of Health Services, Tobacco Control Section, 2006.

Figure 16: Smoking Attributable Cancer Mortality Rate (SACMR) among Adults of 35+ Years in California and the Rest of the U.S.



Source: Smoking-attributable cancer mortality rate (SACMR) is the sum of smoking-attributable mortality rates due to ten cancers of lip/oral cavity/pharynx, esophagus, stomach, pancreas, larynx, trachea/lung/bronchus, cervix uteri, kidney/renal pelvis, urinary bladder, and acute myeloid leukemia. The cancer mortality rates were from the SEER program, standardized to the 2000 US Census population. The Joinpoint Regression program was applied to compare trends and estimate the annual percentage change.
Prepared by: California Department of Health Services, Tobacco Control Section, 2006.

Additionally, the smoking-attributable cancer mortality rate (SACMR) dropped more in California (18.8 percent) than the rest of the U.S. (2.4 percent) during 1979-2002 (Figure 16).[53] The difference and earlier peak in SACMR between California and the rest of the U.S. is partially related to California's smoking behavior changes occurring earlier in California than the rest of the U.S.

From 1988-2004, lung and bronchus cancer rates in California declined at 4 times the rate of decline in the rest of the U. S.

The Future: High Risk Populations and New Frontiers

Despite overall declines in smoking prevalence among all major racial/ethnic groups, there remain significant differences between these groups.

In general, California has enjoyed a steady decline in smoking prevalence as well as cigarette consumption, but segments of the California population are still at high risk for tobacco use. Although smoking prevalence has declined among 18-24 years olds after its peak in 2001, young adults still have the highest smoking prevalence among the four age groups. Some ethnic populations such as African American, American Indian, Korean, and Vietnamese men have significantly higher smoking prevalence than that of the rest of the California population. In addition, regardless of race, a large portion of California's smokers are among those with low socioeconomic status. The CTCP identifies these groups as priority populations and continues to devote significant resources to strengthening tobacco control efforts with these groups.

The CTCP's current priorities and statewide projects include smoke-free multi-unit housing, smoke-free American Indian casinos, a ban on free tobacco product sampling, tobacco-free pharmacies, and strong local tobacco retail licensing. All these project areas address changing the social norms about tobacco and most of them address priority populations.

California will continue to employ the social norm change paradigm and use population-based strategies that have proven to be effective in reducing smoking prevalence and consumption. The CTCP will also extend its policy efforts to meet the needs of California residents who want more places to be smoke-free and will continue to educate people about the tobacco industry's influence in their communities so that this state remains America's largest nonsmoking section.

References

1. Feighery, E. C., N. C. Schleicher, and H. H. Haladjian. 2006. Tobacco Marketing in California Retail Outlets, 2000-05: How the Retail Environment has Changed Over Time and How Community Characteristics Shape it. Public Health Institute, Oakland, CA.
2. Population Research Systems. 2006. Tobacco Event Sponsorship Data Collection Project.
3. Cruz, T. B., and S. Islam. 2005. Targeting of Specific Populations by the Tobacco Industry. Alhambra, California: University of Southern California.
4. American Lung Association of Sacramento-Emigrant Trails. Tobacco use in the movies: Annual Report Card 2005, Thumbs Up! Thumbs Down! Available at http://www.scenesmoking.org/ReportCard2004-05.pdf. Accessed August 7, 2006.
5. Glantz, S. A. and J. Polansky. 2006. Smoking in movies. Chest 129:495.
6. Federal Trade Commission. 2005. Federal Trade Commission Cigarette Report for 2003. Available at http://www.ftc.gov/reports/cigarette05/050809cigrpt.pdf. Accessed August 7, 2006.
7. U.S. Census Bureau. Profile of general demographic characteristics: 2000, Geographic area: California. Available at http://factfinder.census.gov/home/saff/main.html. Accessed August 7, 2006.
8. California Department of Health Services. 1998. A Model of Change: The California Experience in Tobacco Control. Sacramento, CA: California Department of Health Services.
9. State of California, Office of the Attorney General. Press Release: Attorney General Lockyer Announces $5 Million Settlement with R.J. Reynolds to Resolve Lawsuit Over Firm's Distribution of Free Cigarettes State Supreme Court Affirmed RJR's Liability for Violating Sample Restrictions. Available at http://ag.ca.gov/newsalerts/release.php?id=1301. Accessed August 7, 2006.
10. Stevens, C. 1998. Designing an effective counteradvertising campaign—California. Cancer 83:2736-2741.
11. California Department of Health Services. California Adult Tobacco Survey, 1994-2006. Survey instrument is available at http://www.dhs.ca.gov/tobacco/html/resourceseval.htm. Accessed August 8, 2006.
12. California Labor Code §6404.5 (1994).
13. U.S. Department of Health and Human Services. 2006. The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.
14. U.S. Department of Health and Human Services. Remarks at press conference to launch Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. Available at http://www.surgeongeneral.gov/news/speeches/06272006a.html. Accessed August 7, 2006.
15. California Government Code §7596-7598 (2004).
16. California Penal Code §5030.1 (2005).
17. California Department of Health Services. California Adult Tobacco Survey and California Behavioral Risk Factor Surveillance System combined data, 1993-2005. Survey instruments are available at http://www.dhs.ca.gov/tobacco/html/resourceseval.htm.
18. Farkas, A. J., E. A. Gilpin, J. M. Distefan, and J. P. Pierce. 1999. The effects of household and workplace smoking restriction on quitting behaviors. Tob Control 8:261-265.

19. Gilpin, E. A., M. M. White, V. M. White, J. M. Distefan, D. R. Trinidad, L. James, L. Lee, J. Major, S. Kealey, and J. P. Pierce. 2004. Tobacco Control Successes in California: A Focus on Young People, Results from the California Tobacco Surveys, 1990-2002. La Jolla, CA: University of California, San Diego.
20. Field Research Corporation. 2004. Survey of California Adults About State Smoking Policies.
21. Hu T. W., J. Bai, T. E. Keeler, P. G. Barnett, and H. Y. Sung. 1994. The impact of California Proposition 99, a major anti-smoking policy on cigarette consumption. J Public Health Policy 15:26-36.
22. Wakefield, M., and F. Chaloupka. 2000. Effectiveness of comprehensive tobacco control programmes in reducing teenage smoking in the USA. Tob Control 9:177-186.
23. Ross, H., and F. J. Chaloupka. February 2001. The Effects of Cigarette Prices on Youth Smoking. ImpacTEEN Research Paper Series, No. 7.
24. Nicholl, J. 1997. Tobacco tax initiatives to prevent tobacco use: a study of eight statewide campaigns. Cancer 83:2666-2679.
25. Institute of Medicine. 1998. Taking Action to Reduce Tobacco Use. Washington, DC: National Academy of Sciences.
26. Orzechowski, W., and R. C. Walker. 2006. The Tax Burden on Tobacco: Historical Compilation, Volume 40, 2005. Arlington, Va: Orzechowski & Walker.
27. California Penal Code §308 (1991).
28. California Business & Professions Code §22950–22960 (1994).
29. Americans for Non-Smokers' Rights. Local Tobacco Control Ordinance Database—California. Production information available at http://www.no-smoke.org/document.php?id=313.
30. California Senate Bill 1173, Chapter 376 (2001).
31. California Business & Professions Code §22962 (2004).
32. California Business & Professions Code §22970 (2003).
33. California Department of Health Services. Press Release: Illegal Tobacco Sales To Minors In California Fall To An All-Time Low. Available at http://www.dhs.ca.gov/tobacco/documents/press/TobaccoMinors.pdf. Accessed August 8, 2006.
34. California Smokers' Helpline. California Smokers' Helpline Outreach Report, June 2006.
35. Centers for Disease Control and Prevention. August 1999. Best Practices for Comprehensive Tobacco Control Programs—August 1999. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.
36. California Department of Services. California Student Tobacco Survey, 2001-2006. Survey instrument is available at http://www.dhs.ca.gov/tobacco/html/resourceseval.htm. Accessed August 8, 2006.
37. Alamar, B., and S. A. Glantz. 2006. Effect of Increased Social Unacceptability of Cigarette Smoking on Reduction in Cigarette Consumption. Am J of Public Health 96:1359-1363.
38. Fichtenberg, C. M., and S. A. Glantz. 2000. Association of the California Tobacco Control Program with declines in cigarette consumption and mortality from heart disease. The New England Journal of Medicine 343:1772-1777.
39. Barnoya, J., and S. Glantz. 2004. Association of the California tobacco control program with declines in lung cancer incidence. Cancer Causes Control 15:689-695.
40. Cowling, D. W., S. L. Kwong, R. Schlag, J. C. Lloyd, and D. G. Bal. 2000. Declines in lung cancer rates: California, 1988-1997. Morbidity and Mortality Weekly Report 49:1066-1069, updated data included.

41. California Department of Health Services. California Behavioral Risk Factor Survey, 1984-1992. Survey instruments are available at http://www.dhs.ca.gov/tobacco/html/resourceseval.htm.
42. Substance Abuse and Mental Health Services Administration. 2005. Results from the 2004 National Survey on Drug Use and Health: National Findings (Office of Applied Studies, NSDUH Series H-28, DHHS Publication No. SMA 05-4062). Rockville, MD: U.S. Department of Health and Human Services.
43. Al-Delaimy W. K., M. M. White, T. Gilmer, S. H. Zhu, J. P. Pierce. 2006. The California Tobacco Control Program: Can We Maintain the Progress? Results from the California Tobacco Surveys 1990-2005, Volume I. La Jolla, CA: University of California, San Diego.
44. Bye, L., E. Gruskin, G. Greenwood, V. Albright, and K. Krotki. 2005. California Lesbians, Gays, Bisexuals, and Transgender (LGBT) Tobacco Use Survey–2004. Sacramento, CA: California Department of Health Services.
45. Crawford, R., C. Olsen, B. Thompson, and G. Barbour. 2005. California Active Duty Tobacco Use Survey–2004. Sacramento, CA: California Department of Health Services.
46. Carr, K., M. Beers, T. Kassebaum, and M. S. Chen, Jr. 2005. California Korean American Tobacco Use Survey–2004. Sacramento, CA: California Department of Health Services.
47. Carr, K., M. Beers, T. Kassebaum, and M. S. Chen, Jr. 2005. California Chinese American Tobacco Use Survey–2004. Sacramento, CA: California Department of Health Services.
48. McCarthy, W. J., H. Divan, D. Shah, A. Maxwell, B. Freed, R. Bastani, C. A. Bernaards, and Z. Surani. 2005. California Asian Indian Tobacco Survey – 2004. Sacramento, CA: California Department of Health Services.
49. Centers for Disease Control and Prevention. 2006. Cigarette Use Among High School Students–United States, 1991–2005. MMWR 55:724-726.
50. Centers for Disease Control and Prevention. National Youth Tobacco Survey, 2000-2004. Available at http://www.cdc.gov/tobacco/youth.htm. Accessed August 8, 2006.
51. Farkas, A. J. 1999. When does cigarette fading increase the likelihood of future cessation? Ann Behav Med 21:71-76.
52. Kawachi, I., G. A. Colditz, M. J. Stampfer, W. C. Willett, J. E. Manson, B. Rosner, D. J. Hunter, C. H. Hennekens, and F. E. Speizer. 1993. Smoking cessation in relation to total mortality rates in women: A prospective cohort study. Ann Intern Med 119:992-1000.
53. California Department of Health Services. Tobacco Control Section, 1979-2002.